Request for Medical Records

Records will only be sent to the patient themselves, verified medical or record keeping facilities, or to parents or guardians expressly listed on the HIPAA Agreement in the patient's chart. All fields required unless otherwise stated.
NO EXCEPTIONS.

Patient Information:
Patient's Full Name: _____ Date of Birth ___/___/_____
Address: _____City: _____ State:___ ZIP:_____
Primary Phone Number: _____-_____- _____ Email: _____

Records Needed: (Check all that apply)
☐ All Records ☐ All Well Visits ☐ All Acute Visits
☐ Laboratory Results ☐ Inpatient Reports ☐ Vaccination Records
☐ Growth Charts ☐ Other (List) _____
Date Range (Check ONE): ☐ Last 3 Years -OR- ☐ From ___/___/_____ to ___/___/_____

Reason for Request: (REQUIRED)
_____
_____

Method of Delivery: (Check ONE):
Name of Recipient: (office, company, person) _____
☐ Fax to: _____-_____-_____ ☐ In-Person Office Pickup ☐ Mail to Patient Address*
☐ Mail to following address:*
Address: _____City: _____ State:___ ZIP:_____
*Mailed records have a fee of $15

Requestee Information:
Name of Parent/Guardian: _____
Relation to Patient: _____
If requesting your own medical records, list your name and list relation as "self"

Signature: _____ Date: ___/___/_____

This request and authorization for release is valid only for the records requested within the time frame specified above. This form may be submitted by sending it to our office by Fax (727-344-0632) or Email (office@salomonpediatrics.com), or by delivering the completed form to the front desk in-person. Records will be sent or prepared for in-person pickup no later than 30 days from the date of this form's submission, unless you are otherwise notified. If payment is required, records will not be sent or released until a full payment is made to our office via any accepted method of payment. Records cannot be sent via email due to HIPAA privacy guidelines.

Office Use only:

Date Received: *Date of Payment:* *Date Records Sent:*

☐ *Fax* ☐ *Mailed* ☐ *Pickup*